EXHIBIT G

EXHIBIT

A

POLICY CERTIFICATION

The undersigned, Jaimey Bly, being the Manager of Life Policy Administration of Nationwide Life Insurance Company located in Columbus, Ohio, hereby states that the attached portions of policy number L034804300 insuring the life of Gary H. Lupiloff, constitute a true and accurate copy of said policy.

Jaimey Bly

STATE OF OHIO)
) S.S.
COUNTY OF FRANKLIN)

On this 4th day of May 2011, before me, a Notary Public in and for the State of Ohio, appeared Jaimey Bly, known to be the person described herein, and who executed the foregoing instrument and she acknowledged that she voluntarily executed the same.

Margaret Modlich
Notary Public

My Commission Expires: 6-22-2011

NOTARIAL SEAL STATE OF OHIO

MARGARET MODLICH
Notary Public, State of Ohio
My Commission Expires 06-22-2011

Nationwide

GUARANTEED TERM LIFE INSURANCE TO AGE 95 POLICY

PLEASE READ YOUR POLICY CAREFULLY
This policy is a legal contract between you and us.

MEMO TO THE POLICY OWNER:

Thank you for relying on Nationwide Life Insurance Company.

The protection this policy provides is explained on the following pages. To help us serve you better, please let us know if you change your name or address, or wish to change your Beneficiary.

We agree to pay the Death Benefit to the Beneficiary upon receiving proof that the Insured has died while this policy is in force.

---

10 DAY RIGHT TO EXAMINE
To be certain that you are satisfied with this policy, you have a 10-day "free look." Within 10 days after you receive the policy, you may return it to our Home Office or to the agent who delivered it. We will then void the policy as if it had never been in force and refund all premiums paid.

If you have any questions about your policy or need additional insurance service, contact your agent or write to our Home Office. When you write to us, please include the policy number, the Insured's full name, and your current address.

Signed at the Home Office of the Nationwide Life Insurance Company, One Nationwide Plaza, Columbus, Ohio on the Policy Date shown on the policy data page.

Patricia B. Hatler — Secretary

Joseph J. Taylor — President

Renewable once a year until age 95.
Convertible anytime prior to the end of the conversion period, as stated on the policy data pages.
Premiums payable during lifetime of Insured prior to the end of the term of the policy.
Premiums are guaranteed at issue.
Non-Participating - No Dividends.

Nationwide Life Insurance Company
Home Office: One Nationwide Plaza Ã Columbus, Ohio 43215-2220

DUPLICATE

CONTENTS

002246 880002

POLICY DATA PAGE

Owner	GARY H LUPILOFF
Insured	GARY H LUPILOFF
Policy Number	L034664300
Age Of Insured	[redacted]
Sex Of Insured	Male
Rate Type	Non-Tobacco

Policy Date	November 28, 2003
Initial Face Amount	$500,000
Standard Premium Class	

An initial premium on the premium basis as shown in the application is due as of the policy date. Total initial premiums for the available frequencies of payment are:

Annual	Semi Annual	Quarterly	Monthly
$1,030.00	$535.60	$272.95	$91.67

Premiums are payable to the policy anniversary in the year shown in the schedule below or until prior death of the insured.

To determine the guaranteed maximum modal premium for any given age, use the annual premium shown and then:
1. multiply by the factor shown at the right; and
2. add the loading

Payment Mode	Factor	Loading
Semi-annual	x .5200	+ .00
Quarterly	x .2650	+ .00
PAP	x .0890	+ .00

Schedule of Benefits and Annual Premiums

Form Number	Benefits	Annual Premium	Payable To Year
4608	10 YEAR LEVEL GUARANTEED TERM LIFE INSURANCE TO AGE 95	$1,030.00	2013
	TOTAL INITIAL ANNUAL PREMIUM	$1,030.00	

DUPLICATE 1

0022468800003

Insured Name GARY H LUPILOFF
Policy Number L034804300
Policy Date November 28, 2003
Age Of Insured [redacted]
Sex of Insured Male

10 Year Level Guaranteed Term Life Insurance to Age 95 - Base Policy Face Amount -- $500,000

NOTE: Premium is due at the beginning of each premium payment period (ie., Annual, Semi-Annual, Quarterly, Monthly). The premium for the annual premium payment period is disclosed on this page.
NOTE: Conversion may be at any time during the first 5 years, subject to the 'CONVERSION' provision.

POLICY YEAR	AGE	GUARANTEED PREMIUM	POLICY YEAR	AGE	GUARANTEED PREMIUM
1	46	$1,030.00	26	71	$52,915.00
2	47	$1,030.00	27	72	$58,435.00
3	48	$1,030.00	28	73	$65,135.00
4	49	$1,030.00	29	74	$72,495.00
5	50	$1,030.00	30	75	$80,385.00
6	51	$1,030.00	31	76	$88,675.00
7	52	$1,030.00	32	77	$97,365.00
8	53	$1,030.00	33	78	$106,460.00
9	54	$1,030.00	34	79	$116,310.00
10	55	$1,030.00	35	80	$127,170.00
11	56	$11,825.00	36	81	$139,335.00
12	57	$12,980.00	37	82	$153,080.00
13	58	$14,255.00	38	83	$168,280.00
14	59	$15,710.00	39	84	$184,695.00
15	60	$17,320.00	40	85	$201,930.00
16	61	$19,110.00	41	86	$219,760.00
17	62	$21,175.00	42	87	$237,915.00
18	63	$23,515.00	43	88	$256,315.00
19	64	$26,110.00	44	89	$275,225.00
20	65	$28,955.00	45	90	$294,910.00
21	66	$32,030.00	46	91	$315,630.00
22	67	$35,330.00	47	92	$338,765.00
23	68	$38,915.00	48	93	$365,945.00
24	69	$42,880.00	49	94	$402,410.00
25	70	$47,750.00			

DUPLICATE

DEFINITIONS

ATTAINED AGE: The Insured's Attained Age is equal to the Insured's age at issue, shown on the policy data page, plus the number of completed Policy Years.

BENEFICIARY: The Beneficiary is the person to whom the Death Benefits are paid when the Insured dies. The Beneficiary is named in the application, unless changed.

COMPANY: The Company is the Nationwide Life Insurance Company. "We," "our," and "us" refer to the Company.

CONTINGENT BENEFICIARY: The Contingent Beneficiary will become the Beneficiary if the named Beneficiary dies prior to the date of the death of the Insured.

CONTINGENT OWNER: The Contingent Owner will become the Owner if the named Owner dies prior to the date of death of the Insured.

DEATH BENEFIT: The Death Benefit means the amount of money payable to the Beneficiary if the Insured dies while this policy is in force.

HOME OFFICE: The Home Office of the Company is at One Nationwide Plaza, Columbus, Ohio.

INSURED: The Insured is the person whose life is covered by this insurance policy and named in the application.

OWNER: The Owner is as stated in the application unless later changed and endorsed on this policy. "You" or "your" refer to the Owner of this policy.

POLICY ANNIVERSARY: A Policy Anniversary is an anniversary of the Policy Date, shown on the policy data page.

POLICY DATE: The Policy Date is the date the policy provisions take effect. It is shown on the policy data page. Policy Years and policy months are measured from the Policy Date.

POLICY YEAR: The Policy Year starts on an anniversary of the Policy Date, and ends on the day prior to the next anniversary of the Policy Date.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT: The insurance provided by this policy is in return for the application and premiums paid as required in the policy. The policy and a copy of any written application, including any written supplemental applications together make up the entire policy contract. All agreements related to the policy must be on official forms signed by the President or Secretary of the Company. We will not be bound by any promise or representation made by any agent or other persons.

APPLICATION: All statements in an application are considered representations and not warranties. In issuing this policy, we have relied on the statements made in the application to be true and complete. No such statement will be used to void the policy or deny a claim unless that statement is a material misrepresentation.

DUPLICATE

SUICIDE: Suicide of the Insured, while sane or insane, within two years after the Policy Date, is not covered by this policy. In that event, this policy will end and the only amount payable will be the return of any paid premiums to the Beneficiary.

INCONTESTABILITY: After this policy has been in force during the lifetime of the Insured for two years from the Policy Date, we will not contest it for any reason except nonpayment of premiums. After any endorsement or rider has been in force as part of the policy during the lifetime of the Insured for two years, we will not contest it for any reason except nonpayment of premium.

ERROR IN AGE OR SEX: If the age or sex of an Insured has been misstated, all payments and benefits under the policy will be those which the premiums paid would have purchased at the Insured's correct age or sex.

ASSIGNMENT: The Owner may assign all rights under this policy. We will not be bound by the assignment until written notice is received, accepted, and recorded at our Home Office. Assignment will be subject to any amounts owed to us before the assignment was recorded. We are not responsible for the validity of any assignment.

NON-PARTICIPATION: This policy does not participate in our earnings or surplus. This policy does not earn dividends.

DEATH BENEFIT PROVISION

We will pay the Death Benefit to the Beneficiary when we receive satisfactory proof that the death of the Insured occurred while this policy was in force. The part of any premium paid past the policy month of death will be added to the amount paid on death. Any amounts owed to us under the Premium Payment Provisions will be deducted from the amount paid on death.

OWNER AND BENEFICIARY PROVISIONS

OWNERSHIP: The Owner has all rights under the policy during the lifetime of the Insured, unless otherwise provided. If the Owner dies before the Insured, the Owner's estate becomes Owner of the policy, unless the Owner has provided otherwise.

The Owner may name a Contingent Owner or a new Owner at any time during the lifetime of the Insured. Any new designation of an Owner will automatically revoke any existing designation. Any request for change must be made in writing and recorded at our Home Office. It is effective as of the date the written request is signed. It will not apply to any payment made or action taken by us before it was recorded.

BENEFICIARY: The Beneficiary and Contingent Beneficiary on the Policy Date are named in the application. More than one Beneficiary or Contingent Beneficiary may be named. If more than one Beneficiary is designated when the Death Benefit becomes payable, payment to the survivors will be made in equal shares, or in full to the last survivor, unless some other distribution of proceeds is provided.

If any Beneficiary dies or ceases to exist before the Death Benefit becomes payable, that Beneficiary's interest will be paid to any surviving Beneficiaries or Contingent Beneficiaries according to their respective interests, unless you have specified otherwise. If no Beneficiary is living or in existence when the Death Benefit becomes payable, we will consider you or your estate to be the Beneficiary.

CHANGE OF BENEFICIARY: While the Insured is living, you may change any Beneficiary or Contingent Beneficiary. Any change must be in a written form satisfactory to us and recorded at our Home Office. Once recorded, whether or not the Insured is then alive, the change will take effect as of the date you signed it. It will not affect any payment made or action taken by us before it was recorded. We may require that you send us your policy for endorsement before making a change.

PREMIUM PAYMENT PROVISIONS

Premiums are payable for the term of the policy or until the prior death of the Insured. The full premium is payable in advance, and must be paid when due to avoid loss of coverage or reduced benefits. Premiums are payable at our Home Office or to our authorized representative. The authorized representative will accept premiums and provide an official Company receipt signed by the President or Secretary and countersigned by representative. The first premium is due on the Policy Date shown on page 2. After that, premiums are due once a year, or every six months, or every three months, or once a month, depending upon the frequency of payment chosen by the Owner.

All future premiums are guaranteed. You may change the frequency of future premium payments by written request. The change must conform to premium payment rules we have in effect at that time.

PREMIUM CHANGES: All premiums are guaranteed at issue as stated in the policy data pages. The premiums are level for the period shown on the policy data pages. After the level portion of the policy, the premiums are based on an Attained Age scale and increase every year to age 95.

GRACE PERIOD: If any premium after the first one is not paid when due, a period of 31 days from the due date of the unpaid premium will be allowed for payment. The policy will continue in force during this 31 day period. However, if the Insured dies during this 31 day period, any unpaid premium will be deducted from the Death Benefit. In no event will premiums be charged past the policy month of death. This policy will lapse, without value, if premiums are not paid.

REINSTATEMENT: If this policy lapses prior to the expiration date, you may reinstate it. You must apply in writing within five years after the date the first unpaid premium was due. We must also have evidence of insurability that is acceptable to us. All overdue premiums must be paid with 6% compound interest. Compounding interest is added to the amount owed and begins to bear interest itself during the following year.

CONVERSION

This policy may be converted to a level premium, level benefit, permanent plan of whole life or endowment insurance which is currently being offered by Nationwide. Subject to the Company's approval, the conversion may also be made to certain non-level premium, permanent life insurance policies. Conversion may be at any time prior to the end of the conversion period, as stated on the policy data pages. The following will apply:

1. This policy must be in force.
2. Conversion must be applied for in writing.
3. The Insured's Attained Age must be less than 75.
4. Evidence of insurability is not needed.
5. The face amount of the new policy may be for an amount up to the face amount of this policy at the time the request for conversion is made, but not less than our published minimum for the plan selected.

6. The new policy must be for a plan of insurance we are issuing on the date of conversion.

7. Premiums for the converted policy will not be waived because of any existing disability at the time of conversion.

8. Supplemental benefits cannot be added without evidence of insurability and consent of the Company.

The Policy Date of the new policy will be the date of conversion. The premium for the new policy will be based on the same class of risk as this policy and the Attained Age of the Insured on the date of conversion.

The contestable and suicide periods in the new policy will start on the Policy Date of this policy.

POLICY SETTLEMENT

Policy settlement means payment of the Death Benefit when the Insured dies.

Policy settlement may be paid in a lump sum. Options for other methods of settlement are also available. One settlement option or a combination of options may be chosen. A settlement option other than lump sum may be chosen only if the total amount placed under the option is at least $2,000.00 and each payment is at least $20.00.

While this policy is in force, the Owner may choose, revoke or change settlement options at any time. If no settlement option has been chosen before the Insured has died, the Beneficiary may choose one. If no other settlement option has been chosen, payment will be made in a lump sum.

Settlement options must be chosen, revoked or changed by proper written request. After an option, revocation, or change is recorded at our Home Office, it will become effective as of the date it was requested. We may require proof of age of any person to be paid under a settlement option. Any change of Beneficiary will automatically revoke any settlement option that is in effect.

At the time of policy settlement under any settlement option other than lump sum, we will issue a settlement contract in exchange for the policy. The effective date of the settlement contract will be the date the Insured died.

Settlement option payments are not assignable. To the extent allowed by law, settlement option payments are not subject to the claims of creditors or to legal process.

Options 1, 2, 4 and the guaranteed period of Option 3, provide for payment of interest at the rate of 2-1/2% per year. We will determine once a year any interest to be paid in excess of the rate of 2-1/2%.

OPTIONS

1. INTEREST INCOME: Any amount payable under this option may be left with us and will receive interest of at least 2-1/2% annually. This interest may be either left to accumulate or it may be paid at the end of every 12, 6, 3, or 1 month interval from the effective date of the settlement contract. Upon receipt of proper written request, the amount left with us may be withdrawn.

2. INCOME FOR A FIXED PERIOD: Any amount payable under this option will be paid over the number of years selected. The amount payable monthly for each $1,000 left with us will be at least as much as the amount shown in the Option 2 Table. If chosen, payments will be made at the beginning of each 12, 6, 3, or 1 month interval, starting with the effective date of the settlement contract. Each payment includes a portion of the amount left with us and interest. Upon receipt of proper written request, the amount left with us may be withdrawn.

3. **LIFE INCOME WITH PAYMENTS GUARANTEED:** Any amount payable under this option will be paid during the named payee's lifetime. A guaranteed period of 10, 15, or 20 years may be selected. Payments will continue to the end of this period even if the payee dies. The amount payable monthly for each $1,000 left with us is shown in the Option 3 Table. If chosen, payments will be made at the beginning of each 12, 6, 3, or 1 month interval starting with the effective date of the settlement contract. Amounts left with us under this option may not be withdrawn.

4. **FIXED INCOME FOR VARYING PERIODS:** Any amount payable under this option will be paid in a fixed amount until the amount left under this option, and interest, has been paid. The total amount payable each year may not be less than 5% of the amount left under this option. Interest paid under this option will be at the rate of at least 2-1/2% compounded annually. If chosen, payments will be made at the beginning of each 12, 6, 3, or 1 month interval, starting with the effective date of the settlement contract. Upon receipt of proper written request, the amount left with us may be withdrawn.

5. **JOINT AND SURVIVOR LIFE INCOME:** Any amount payable under this option will be paid and continued during the lifetimes of the named payees, as long as either payee is living. Upon request, the Company will furnish information as to the monthly amounts payable for each $1,000 of proceeds. (Life Income amounts payable for other combinations of age and sex will be furnished on request.) If chosen, payments will be made jointly at the beginning of each 12, 6, 3, or 1 month interval, starting with the effective date of the settlement contract. Amounts left with us under this option may not be withdrawn.

6. **LIFE ANNUITY:** Any amount payable under this option will be paid during the lifetime of the named payee or the lifetimes of the named payees. The amount payable will be 102% of our current annuity purchase rate on the effective date of the settlement contract. Annuity purchase rates are subject to change. Upon request, we will quote the amount currently payable under this settlement option. If chosen, payments will be made at the end of each 12, 6, 3, or 1 month interval from the effective date of the settlement contract. Amounts left with us under this option may not be withdrawn.

TABLES FOR SETTLEMENT OPTIONS

OPTION 2

Monthly Installments for each $1,000 of Proceeds
Option 2 - Income for a Fixed Period

Number of Years Specified	Amount of Each Installment	Number of Years Specified	Amount of Each Installment
1	$84.28	16	$6.30
2	42.66	17	6.00
3	28.79	18	5.73
4	21.86	19	5.49
5	17.70	20	5.27
6	14.93	21	5.08
7	12.95	22	4.90
8	11.47	23	4.74
9	10.32	24	4.60
10	9.39	25	4.46
11	8.64	26	4.34
12	8.02	27	4.22
13	7.49	28	4.12
14	7.03	29	4.02
15	6.64	30	3.93

Annual, semi-annual or quarterly payments are 11.865, 5.969 and 2.994 respectively times the monthly installments.

OPTION 3

Monthly Installments for each $1,000 of Proceeds
Option 3 - Life Income with Payments Guaranteed
REFER TO NEXT PAGE

OPTION 5

Monthly Installments for each $1,000 of Proceeds
Option 5 - Joint & Survivor Life Income

M/F	50	55	60	65	70	75	80	85	90	95	100
50	$2.86	$2.96	$3.04	$3.11	$3.17	$3.21	$3.24	$3.26	$3.28	$3.29	$3.29
55	$2.92	$3.04	$3.15	$3.26	$3.35	$3.43	$3.48	$3.52	$3.55	$3.56	$3.57
60	$2.96	$3.11	$3.26	$3.41	$3.55	$3.67	$3.77	$3.84	$3.88	$3.91	$3.93
65	$3.00	$3.17	$3.35	$3.55	$3.75	$3.94	$4.10	$4.22	$4.31	$4.37	$4.40
70	$3.02	$3.21	$3.43	$3.67	$3.94	$4.21	$4.47	$4.68	$4.85	$4.96	$5.03
75	$3.04	$3.24	$3.48	$3.77	$4.10	$4.47	$4.85	$5.20	$5.50	$5.72	$5.86
80	$3.05	$3.26	$3.52	$3.84	$4.22	$4.68	$5.20	$5.73	$6.22	$6.63	$6.92
85	$3.06	$3.28	$3.55	$3.88	$4.31	$4.85	$5.50	$6.22	$6.98	$7.67	$8.22
90	$3.07	$3.29	$3.56	$3.91	$4.37	$4.96	$5.72	$6.63	$7.67	$8.73	$9.68
95	$3.07	$3.29	$3.57	$3.93	$4.40	$5.03	$5.86	$6.92	$8.22	$9.68	$11.16
100	$3.07	$3.30	$3.58	$3.94	$4.42	$5.07	$5.96	$7.12	$8.62	$10.46	$12.49

OPTION 3

Monthly Installments for each $1,000 of Proceeds
Option 3 - Life Income with Payments Guaranteed

Age of Payee Last Birthday		Guaranteed Period Years			Age of Payee Last Birthday		Guaranteed Period Years			Age of Payee Last Birthday		Guaranteed Period Years		
Male	Female	10	15	20	Male	Female	10	15	20	Male	Female	10	15	20
5 & under	10 & under	$2.33	$2.33	$2.32	35	40	$2.75	$2.75	$2.75	65	70	$4.37	$4.27	$4.12
6	11	$2.33	$2.33	$2.33	36	41	$2.78	$2.78	$2.77	66	71	$4.48	$4.36	$4.19
7	12	$2.34	$2.34	$2.34	37	42	$2.81	$2.80	$2.80	67	72	$4.59	$4.45	$4.26
8	13	$2.35	$2.35	$2.35	38	43	$2.83	$2.83	$2.82	68	73	$4.71	$4.55	$4.33
9	14	$2.36	$2.36	$2.36	39	44	$2.86	$2.86	$2.85	69	74	$4.83	$4.65	$4.40
10	15	$2.37	$2.37	$2.37	40	45	$2.89	$2.89	$2.88	70	75	$4.96	$4.75	$4.47
11	16	$2.38	$2.38	$2.38	41	46	$2.92	$2.92	$2.91	71	76	$5.10	$4.86	$4.54
12	17	$2.39	$2.39	$2.39	42	47	$2.96	$2.95	$2.94	72	77	$5.24	$4.97	$4.61
13	18	$2.40	$2.40	$2.40	43	48	$2.99	$2.99	$2.97	73	78	$5.39	$5.07	$4.68
14	19	$2.41	$2.41	$2.41	44	49	$3.03	$3.02	$3.01	74	79	$5.55	$5.18	$4.75
15	20	$2.42	$2.42	$2.42	45	50	$3.07	$3.06	$3.04	75	80	$5.71	$5.29	$4.81
16	21	$2.43	$2.43	$2.43	46	51	$3.11	$3.10	$3.08	76	81	$5.87	$5.40	$4.87
17	22	$2.44	$2.44	$2.44	47	52	$3.15	$3.14	$3.12	77	82	$6.05	$5.51	$4.92
18	23	$2.46	$2.45	$2.45	48	53	$3.19	$3.18	$3.16	78	83	$6.22	$5.61	$4.97
19	24	$2.47	$2.47	$2.46	49	54	$3.24	$3.22	$3.20	79	84	$6.40	$5.72	$5.02
20	25	$2.48	$2.48	$2.48	50	55	$3.29	$3.27	$3.25	80	85	$6.58	$5.82	$5.06
21	26	$2.49	$2.49	$2.49	51	56	$3.34	$3.32	$3.29	81	86	$6.77	$5.91	$5.10
22	27	$2.51	$2.51	$2.50	52	57	$3.39	$3.37	$3.34	82	87	$6.96	$6.00	$5.13
23	28	$2.52	$2.52	$2.52	53	58	$3.45	$3.42	$3.39	83	88	$7.14	$6.09	$5.16
24	29	$2.54	$2.54	$2.53	54	59	$3.50	$3.48	$3.44	84	89	$7.33	$6.16	$5.18
25	30	$2.55	$2.55	$2.55	55	60	$3.56	$3.53	$3.49	85	90	$7.51	$6.24	$5.21
26	31	$2.57	$2.57	$2.57	56	61	$3.63	$3.59	$3.54	86	91	$7.69	$6.30	$5.22
27	32	$2.59	$2.59	$2.58	57	62	$3.69	$3.66	$3.60	87	92	$7.87	$6.36	$5.24
28	33	$2.61	$2.60	$2.60	58	63	$3.76	$3.72	$3.66	88	93	$8.03	$6.41	$5.25
29	34	$2.62	$2.62	$2.62	59	64	$3.84	$3.79	$3.72	89	94	$8.19	$6.46	$5.26
30	35	$2.64	$2.64	$2.64	60	65	$3.91	$3.86	$3.78	90	95	$8.34	$6.50	$5.26
31	36	$2.66	$2.66	$2.66	61	66	$3.99	$3.93	$3.84	91	96	$8.48	$6.53	$5.27
32	37	$2.68	$2.68	$2.68	62	67	$4.08	$4.01	$3.91	92	97	$8.61	$6.56	$5.27
33	38	$2.71	$2.70	$2.70	63	68	$4.17	$4.09	$3.98	93	98	$8.73	$6.58	$5.27
34	39	$2.73	$2.73	$2.72	64	69	$4.27	$4.18	$4.05	94	99	$8.84	$6.60	$5.27
										95 & over	100 & over	$8.94	$6.61	$5.27

If the income payable for a specific guaranteed period is equal to that for other guarantee periods the longer period will be deemed to have been elected.

DUPLICATE

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NATIONWIDE LIFE INSURANCE COMPANY

ENDORSEMENTS (Endorsements may be made only by the Company at the Home Office)

001785710001

☐ NATIONWIDE LIFE INSURANCE COMPANY
☐ NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Life Insurance
P.O. Box 182835 Columbus, Ohio 43218-2835

PART A

1. PROPOSED PRIMARY INSURED

a Name (First, MI, Last) Gary Harmon Luginbill | b Social Security Number [redacted]
c Residence Street Address (include city, state and zip code) [redacted]
d County Oakland | e Date of Birth [redacted] | f State of Birth Michigan
g Sex ☒ M ☐ F | h Age 46 | i Marital Status Single | j Driver's License # and State of Issue [redacted]
k Former Name (if applicable) NA | l Occupation Newspaper Sales | m Employer MID Newspapers
n Can you read and understand English? ☒ Yes ☐ No | o Citizenship (if other, submit Foreign Supplement) ☒ U.S. ☐ Canada ☐ Other | p How long have you been in the U.S.? 46 years
q Telephone (Home) [redacted] | r Best time to call 8:00 AM/PM | s Telephone (Business) [redacted] | t Best time to call CALL AM/PM

2. PROPOSED INSURED (CHILD/GRANDCHILDREN) (Complete if applicable)

NAME OF INSURED(S)	DATE OF BIRTH	AGE	SEX	HEIGHT	WEIGHT	STATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO INSURED

3. JOINT/SPOUSE PROPOSED INSURED ADDITIONAL INFORMATION (Complete if applicable)

a Residence Street Address (include city, state and zip code)
b Former Name (if applicable) | c Occupation | d Employer
e Driver's License # and State of Issue | f County | g Marital Status
h Can you read and understand English? ☐ Yes ☐ No | i Citizenship (if other submit Foreign Supplement) ☐ U.S. ☐ Canada ☐ Other | j How long have you been in the U.S.?
k Telephone (Home) ( ) | l Best time to call ____ AM/PM | m Telephone (Business) ( ) | n Best time to call ____ AM/PM

4. OWNER (The Primary Insured (Joint Insureds in case of Survivorship) will own the policy unless indicated here. If the Owner is a Trust, complete the Trust Information Section below.)

a Name (First, MI, Last) | b Social Security Number or Tax ID
c Residence Street Address (include city, state and zip code)
d County | e Relationship to Insured(s) | f Telephone Number | g Date of Birth
(Only complete h, i, and k for Individual life policies on Juveniles (ages 0-16 when applying for Owner's Death or for Owner's Death or Disability Benefits)
h Occupation | i Height | j Weight | k State of Birth
l Trust Information (Please submit copy of first and signature pages of Trust document)

EXACT NAME OF TRUST	TRUST TAX ID NUMBER	CURRENT TRUSTEE(S)	DATE OF TRUST

5. CONTINGENT OWNER

a Name (First, MI, Last) | b Social Security Number or Tax ID
c Residence Street Address (include city, state and zip code)
d County | e Relationship to Insured(s) | f Telephone Number | g Date of Birth

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DUPLICATE

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6. LIFE INSURANCE PLAN

a. Plan *(If a Variable Life product is being applied for, the Variable Life Fund Supplement MUST be completed in conjunction with this application.)*
GTL 10

b. Total Specified Face Amount *(including Additional Protection Rider)*	c. Additional Protection Rider Amount: *(Individual Life case only)*	d. Supplemental Coverage Percentage *(Survivorship case only)*
$ 500,000	NA	NA

e. Initial Premium Deposit *(paid with application)*	f. Planned Premium *(Check plan for availability)*			
$ 200.00	☐ Single Premium $		☐ Semi-Annual $	
	☐ Annual $		☒ Quarterly $	197.43
	☐ Monthly EFT *(Complete Part A, #7)*		☐	$

FOR INDIVIDUAL VARIABLE UNIVERSAL LIFE PLAN ONLY *(Check plan for availability)*

g. Death Benefit Option *(If no option is selected here Option 1 is elected)*
- ☐ Option 1 *(The Specified Amount, or a multiple of the Cash Value whichever is greater)*.
- ☐ Option 2 *(The Specified Amount, plus the Cash Value, or a multiple of the Cash Value, whichever is greater)*.
- ☐ Option 3 *(The Specified Amount, plus the Premium Accumulation at ____% interest or a multiple of the Cash Value, whichever is greater)*

h. Internal Revenue Code Life Insurance Qualification Test *(If no selection is made here, Guideline Premium/Cash Value Corridor Test is elected)*.
☐ Guideline Premium/Cash Value Corridor Test ☐ Cash Value Accumulation Test

i. Optional Benefit Riders
- ☐ Accidental Death Benefit Rider $
- ☐ Adjusted Sales Load Rider
  ____% *(in whole percentages only)* waived for ____ years
- ☐ Child Rider $
- ☐ Long Term Care Rider* $
- ☐ Maturity Extension Endorsement for Specified Amount
- ☐ Premium Waiver Rider $
- ☐ Spouse Rider $
- ☐ Waiver of Monthly Deduction Rider
- ☐ Other Rider(s)

*Complete Supplement for Long Term Care Rider

FOR SURVIVORSHIP LIFE PLAN ONLY *(Check plan for availability)*

j. Death Benefit Option *(If no option is selected here, Option 1 is elected)*
- ☐ Option 1 *(The Specified Amount, or a multiple of the Cash Value, whichever is greater)*.
- ☐ Option 2 *(The Specified Amount plus the Cash Value, or a multiple of the Cash Value whichever is greater)*
- ☐ Option 3 *(The Specified Amount plus the Premium Accumulation at ____% interest or a multiple of the Cash Value, whichever is greater)*.

k. Internal Revenue Code Life Insurance Qualification Test *(If no selection is made here, Guideline Premium/Cash Value Corridor Test is elected)*.
☐ Guideline Premium/Cash Value Corridor Test ☐ Cash Value Accumulation Test

l. Optional Benefit Riders
- ☐ Adjusted Sales Load Rider
  ____% *(in whole percentages only)* waived for ____ years
- ☐ Estate Protection Rider $
- ☐ Maturity Extension Endorsement for Specified Amount
- ☐ Policy Split Option Rider
- ☐ Other Rider(s)

FOR UNIVERSAL LIFE PLAN ONLY *(Check plan for availability)*

m. Death Benefit Option *(If no option is selected here Option 1 is elected)*
- ☐ Option 1 *(The Specified Amount, or a multiple of the Accumulated Value, whichever is greater.)*.
- ☐ Option 2 *(The Specified Amount plus the Accumulated Value, or a multiple of the Accumulated Value whichever is greater)*

n. Internal Revenue Code Life Insurance Qualification Test *(If no selection is made here Guideline Premium/Cash Value Corridor Test is elected.)*
☐ Guideline Premium/Cash Value Corridor Test ☐ Cash Value Accumulation Test

o. Optional Benefit Riders
- ☐ Accidental Death - Amount $
- ☐ Child Rider $
- ☐ Guaranteed Option to Increase Specified Amount $
- ☐ Lapse Protection Rider
- ☐ Maturity Extension Endorsement for Specified Amount
- ☐ Spouse Rider $
- ☐ Waiver of Monthly Deduction Rider
- ☐ Other Rider(s)

FOR WHOLE LIFE PLAN ONLY *(Check plan for availability)*

p. Optional Benefit Riders
- ☐ 10 Year Spouse Rider $
- ☐ 20 Year Spouse Rider $
- ☐ Accidental Death - Amount $
- ☐ Child Rider $
- ☐ Excess Credit Option
- ☐ Guaranteed Insurability – Amount $
- ☐ Owner's Death *(Complete Part B, #14 for Owner)*
- ☐ Owner's Death or Disability *(Complete Part B, #14 for Owner)*
- ☐ Waiver of Premium Benefit
- ☐ Other Rider(s)

If available, issue with Automatic Premium Loan, unless indicated by checking this box ☐

FOR TERM LIFE PLAN ONLY *(Check plan for availability)*

q. Optional Benefit Riders
- ☐ 10 Year Spouse Rider $
- ☐ 20 Year Spouse Rider $
- ☐ Other Rider(s)
- ☐ Child Rider $
- ☐ Waiver of Premium Benefit

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7. ELECTRONIC FUNDS TRANSFER AUTHORIZATION

Financial Institution Name	Financial Institution Phone Number
Financial Institution Address	
Account Number	Transit/ABA Number
Monthly EFT Amount / Draft Date	☐ *Checking (Attach a pre-printed Voided Check. Starter Checks will not be accepted.) ☐ *Savings (Attach a Voided Deposit Slip with account number and routing number.)

*By providing my financial institution name and account information, I hereby authorize Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company to initiate debit entries to my checking/savings account indicated above and the Financial Institution to debit the same such account.

8. BENEFICIARY DESIGNATIONS *(If Joint Plan, specify each Primary Insured's beneficiary designation-use #19, if necessary. When more than one beneficiary is designated payments to the beneficiaries surviving the Insured will be made in equal shares or in full to the last surviving beneficiary unless some other distribution of proceeds is provided. If the Beneficiary is a Trust complete the Trust Information Section below.)*

%	PRIMARY	CONTINGENT	BENEFICIARY NAME	DATE OF BIRTH	RELATIONSHIP TO INSURED(S)	SOCIAL SECURITY NUMBER
a. Proposed Primary Insured						
	☒	☐	William Kenneth [redacted]	[redacted]	Father (Surviving)	[redacted]
	☐	☒	Marsha Lynn [redacted]	[redacted]	Step-Mother	[redacted]
	☐	☐	Nicole Renee [redacted]	[redacted]	Daughter	[redacted]
b. Proposed Insured (Joint/Spouse)						
	☐	☐				
	☐	☐				
	☐	☐				

c. Trust Information

EXACT NAME OF TRUST	TRUST TAX ID NUMBER	CURRENT TRUSTEE(S)	DATE OF TRUST

9. PAYOR - *(If someone other than the Insured(s) or the Owner is to be billed for the premiums for this policy.)*

a. Name *(First, MI, Last)*

b. Residence Street Address *(include city, state and zip code)*

10. INSURANCE INFORMATION

a. Will any Life Insurance or Annuities for this or any other company be replaced, discontinued, reduced or changed if insurance now applied for is issued? ☐ Yes ☑ No *(If yes, please complete appropriate replacement. If this is an Internal Revenue Code Section 1035 Exchange, please check above and attach 1035 forms. If this is a Nationwide Term Conversion and you are not the Owner of the term policy or you are not converting the entire amount of the term policy, please enclose a term conversion application.)*

b. Do you currently have any Life Insurance or Annuities in force? ☐ Yes ☐ No *(If yes, please list below.)*

PERSON	COMPANY	POLICY NUMBER	AMOUNT	YEAR ISSUED	ACCIDENTAL DEATH	ANYTERM CONVERSION	TO BE REPLACED	1035
	N/A		$		$	☐	☐ Yes ☐ No	☐
			$		$	☐	☐ Yes ☐ No	☐
			$		$	☐	☐ Yes ☐ No	☐
			$		$	☐	☐ Yes ☐ No	☐
			$		$	☐	☐ Yes ☐ No	☐
			$		$	☐	☐ Yes ☐ No	☐
			$		$	☐	☐ Yes ☐ No	☐

c. Is any person here proposed for coverage now applying for Life Insurance or Annuities with any other company? ☐ Yes ☑ No
(If yes, please provide name of company, amount applied for and purpose of coverage.)

DUPLICATE

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PART B

11. PERSONAL INFORMATION

All questions are to be answered by each Proposed Insured. For each yes answer, provide details below.	PROPOSED INSURED Yes	PROPOSED INSURED No	JOINT/SPOUSE PROPOSED INSURED Yes	JOINT/SPOUSE PROPOSED INSURED No	ANY CHILD Yes	ANY CHILD No
a Have you ever had any application for Life or Health Insurance (or for reinstatement for Life or Health Insurance) declined, postponed, rated-up or limited? (If yes, provide details.)	☐	☑	☐	☑	☐	☑
b Have you ever applied for or received disability payments for any illness or injury? (If yes, provide details.)	☐	☑	☐	☑	☐	☑
c In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member, organized racing of an automobile, motorcycle or any type of motor-powered vehicle, scuba diving, mountain climbing, hang-gliding, parachuting, sky diving, bungee jumping, or any type of body-contact or life-threatening sport? (If yes, complete an Aviation/Hazardous Activities Questionnaire.)	☐	☑	☐	☑	☐	☑
d Have you ever had your driver's license suspended or revoked or been convicted of driving while impaired or intoxicated, or been convicted in the past 3 years of more than one moving violation? (If yes, provide details.)	☐	☑	☐	☑	☐	☑
e Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? (If yes, complete Drug Questionnaire.)	☐	☑	☐	☑	☐	☑
f Have you ever been charged with a violation of any criminal law? (If yes, provide details.)	☑	☐	☐	☑	☐	☑
g Have you had any bankruptcies in the past 7 years or have any suits or judgments pending against you at this time? (If yes, provide details.)	☑	☐	☐	☑	☐	☑
h Do you plan to travel or reside outside of the United States or Canada? (If yes, complete Supplement for Foreign Nationals or Travel.)	☐	☑	☐	☑	☐	☑
i Do you belong to or intend to join any active or reserve military or naval organization? (If yes, complete Military Status Questionnaire.)	☐	☑	☐	☑	☐	☑
j Do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? (If yes, provide relationship to Proposed Insured(s), age at death and cause of death, and if cancer, provide type.)	☐	☑	☐	☑	☐	☑

Details of any yes answers (indicate name of person). (If more space is needed, an additional blank sheet may be attached.):

D. Casey [redacted] Laughlin 1998: Federal Bank Fraud - Guilty

D. " " 2001: Civil Action [redacted] Settled

12. TOBACCO USE

a PROPOSED INSURED:
Have you used tobacco or nicotine in any form in the last 5 years? ☐ Yes ☑ No Last 12 months? ☐ Yes ☑ No
If yes, specify the form of tobacco or nicotine products used: ☐ cigarettes ☐ pipe ☐ cigars ☐ chewing tobacco ☐ snuff ☐ other tobacco ☐ nicotine products (gum, patch, etc.)

b JOINT/SPOUSE PROPOSED INSURED:
Have you used tobacco or nicotine in any form in the last 5 years? ☐ Yes ☑ No Last 12 months? ☐ Yes ☑ No
If yes, specify the form of tobacco or nicotine products used: ☐ cigarettes ☐ pipe ☐ cigars ☐ chewing tobacco ☐ snuff ☐ other tobacco ☐ nicotine products (gum, patch, etc.)

13. PHYSICAL MEASUREMENTS

INSURED	HEIGHT	WEIGHT CURRENT	WEIGHT 1 YEAR AGO	REASON FOR WEIGHT GAIN OR LOSS
Proposed Insured	5' 7"	180 lbs	156 lbs	

14. PERSONAL PHYSICIANS

	PROPOSED INSURED	JOINT/SPOUSE PROPOSED INSURED	ANY CHILD
Name of Personal Physician	Dr. Vickee Sanders		
Address	[redacted] Farmington Hills MI 48336		
Telephone Number	[redacted]		
Date last consulted	2009		
Reason last consulted	Physical		
Treatment given or medication prescribed	Medication - Pravachol 20mg		

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#16. MEDICAL QUESTIONS

All questions are to be answered by each Proposed Insured. For each yes answer, circle the appropriate item and provide details in #17.
To the best of your knowledge and belief, has anyone here proposed for insurance consulted a member of the medical profession for, been treated for, taken medication for, or been diagnosed as having:

		PROPOSED INSURED		JOINT/SPOUSE PROPOSED INSURED		ANY CHILD	
		Yes	No	Yes	No	Yes	No
a	AIDS (Acquired Immune Deficiency Syndrome), or received positive results of an HIV (Human Immunodeficiency Virus) test using the ELISA-ELISA-Western Blot Testing Sequence?	☐	☑	☐	☑	☐	☑
b	Heart disease including heart attack, angina, or other chest pain, high blood pressure, shortness of breath, palpitations, heart murmur, phlebitis, or any other disorder of the heart or blood vessels?	☐	☑	☐	☑	☐	☑
c	Headaches, seizures, epilepsy, stroke, Alzheimer's disease, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	☐	☑	☐	☑	☐	☑
d	Depression, nervous, affective disorder, psychosis, or any other mental disorder?	☐	☑	☐	☑	☐	☑
e	Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	☐	☑	☐	☑	☐	☑
f	Colitis, ulcer, persistent diarrhea, rectal bleeding, or any other disease or disorder of the esophagus or digestive tract?	☐	☑	☐	☑	☐	☑
g	Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	☐	☑	☐	☑	☐	☑
h	Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	☐	☑	☐	☑	☐	☑
i	Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	☐	☑	☐	☑	☐	☑
j	Arthritis, rheumatoid arthritis, osteoporosis, or any paralysis or chronic back or muscle condition?	☐	☑	☐	☑	☐	☑
k	Alcoholism, narcotic addiction, drug use, or hallucinogens?	☐	☑	☐	☑	☐	☑
l	Any disease or disorder of the liver, ears, nose or throat?	☐	☑	☐	☑	☐	☑

#16. SUPPLEMENTAL MEDICAL INFORMATION

All questions are to be answered by each Proposed Insured. For each yes answer, circle the appropriate item and provide details in #17.
To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:

		PROPOSED INSURED		JOINT/SPOUSE PROPOSED INSURED		ANY CHILD	
		Yes	No	Yes	No	Yes	No
a	Consulted, or been examined or treated by any physician, chiropractor, or other medical practitioner or by any hospital, clinic, or other medical facility not already disclosed on this application? (If it was for a "check up", account physical, employment physical, etc., so state and give findings and results in #17.)	☑	☐	☐	☐	☐	☐
b	Had any disease, disorder, injury, or symptom not already disclosed on this application?	☐	☑	☐	☐	☐	☐
c	Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	☐	☑	☐	☐	☐	☐
d	Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	☐	☑	☐	☐	☐	☐

#17. DETAILS OF MEDICAL HISTORY (If more space is needed, an additional blank sheet may be attached)

QUESTION # AND LETTER	PERSON	DATES	DETAILS (Be specific. Give full names, addresses and telephone numbers (if available) of physicians, hospitals, etc.)
16 a.	Dr. L. Scott Grant	December 2010 - January 2011	Check up and prescription for a cough.

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PART C

18. TAXPAYER IDENTIFICATION NUMBER
Under the Interest and Dividend Compliance Act of 1983, persons owning insurance policies are required to provide the Company with certification that their taxpayer identification number is correct (For most individuals, this is their Social Security Number) If you do not provide us with certification of this number, you may be subject to a $50 penalty imposed by the Internal Revenue Service. In addition, we will be forced to withhold 31% from interest and other payments we make to you (known as backup withholding) It is not an additional tax, since the amount withheld may be applied against any tax you owe. If withholding results in an overpayment of taxes, a refund may be available ☐ Check this box if the Internal Revenue Service has notified you that you are subject to backup withholding Otherwise, your signature on this application is certification that the taxpayer identification number on this application is true, correct, and complete The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding
19. SPECIAL INSTRUCTIONS *(If more space is needed, an additional blank sheet may be attached)*

L034804300

AMENDMENT
OF APPLICATION FOR INSURANCE TO
NATIONWIDE LIFE INSURANCE COMPANY
COLUMBUS, OHIO 43215

I hereby amend my application for insurance to the Nationwide Life Insurance Company on the life of Gary Lupiloff dated November 11, 2003 as follows:

The policy was issued with Non-Tobacco rates.

I hereby agree that these changes shall be an amendment to and form a part of the original application and of the policy issued thereunder, if any.

Signed at Bloom, MI on 4/26, 2004
CITY, STATE MONTH, DAY YEAR

X _____ X _____
SIGNATURE OF PROPOSED INSURED (NOT REQUIRED IF UNDER AGE 10) Gary Lupiloff
SIGNATURE OF OWNER(S) (IF OTHER THAN PROPOSED INSURED) Gary Lupiloff

Witness X _____
(REPRESENTATIVE)

RETURN ORIGINAL SIGNED COPY TO NATIONWIDE

DUPLICATE

Mail To: ☒ Nationwide Life Insurance Company
☐ Nationwide Life and Annuity Insurance Company

☐ Life Underwriting	☐ COLI/BOLI, 1-11-08	☐ Group
P.O. Box 182835	One Nationwide Plaza	P.O. Box 8026
Columbus, OH 43218-2835	Columbus, OH 43215-2220	Dublin, OH 43016-9902
1-866-678-LIFE (5433)		

MEDICAL EXAMINATION

(Part 2 of an application to Nationwide Insurance for Life or Health Insurance)

Name of Proposed Insured *(please print)*	Social Security No.	Date of Birth
Gary Harmon Lupiloff	[redacted]	[redacted]

Physicians: Include both primary care and specialists and date last consulted. *(If more than two physicians, indicate so under "details".)*

Name Dr. Victor C. Gruden	Name
Address 28100 Grand River Ave	Address
Telephone 248-471-3844	Telephone
Medical specialty Phys. Medicine & Rehab	Medical specialty
Date and reason last consulted Hand Blood Serum	Date and reason last consulted

Current medications to include prescription, over-the-counter medication taken regularly, dietary supplements, "natural" or herbal medications. Give details of dosage and frequency. Celebrex Naproxen

Have you ever had any indication of, been evaluated, diagnosed, or treated by a medical professional for:	Yes	No
1a. Heart disease, including heart attack, angina or chest pain, shortness of breath, cardiomyopathy, congestive heart failure, heart murmur, or valvular heart disease, congenital heart defect, or other disorders of the heart?	☐	☒
b. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	☐	☒
c. Heart catheterization, abnormal electrocardiogram, or other cardiac test, coronary bypass surgery, or angioplasty?	☐	☒
2. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	☐	☒
3a. Diabetes or abnormal blood sugar?	☐	☒
b. Thyroid, adrenal, parathyroid, pituitary, or other glandular disorder?	☐	☒
4a. Cancer, leukemia, lymphoma or any malignant or benign tumor, cyst, or polyps?	☐	☒
b. Any abnormal screening tests for cancer including PSA (prostate specific antigen), mammogram, or PAP smears?	☐	☒
5. AIDS (Acquired Immune Deficiency Syndrome), or received positive results of an HIV (Human Immunodeficiency Virus) test using the ELISA-ELISA-Western Blot Testing Sequence?	☐	☒
6. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, platelets, or clotting factors?	☐	☒
7. Stroke, TIA, paralysis, epilepsy, seizures, fainting, tremor, Parkinson's disease, mental retardation, cerebral palsy, multiple sclerosis, Alzheimer's disease, ALS (Lou Gehrig's disease), or any other symptoms or disorders of the nerves or brain?	☐	☒
8a. Asthma, emphysema (COPD), tuberculosis, or chronic bronchitis?	☐	☒
b. Persistent hoarseness or cough, an abnormal chest X-ray or other lung disease or disorder?	☐	☒
9a. Ulcer, intestinal bleeding, ulcerative colitis, Crohn's disease, diverticulitis, hernia, or any other disorder of the esophagus, stomach, or intestines?	☐	☒
b. Jaundice, cirrhosis, hepatitis, or any disease of the liver, pancreas or gall bladder?	☐	☒
10a. Sugar, protein, or blood in the urine, kidney stone, glomerulonephritis, or history of nephrectomy?	☐	☒
b. Other disorders of the kidney, bladder, ureter, urethra, or any part of the urinary system?	☐	☒
11a. Reproductive system including uterine fibroids, endometriosis, or ovarian cyst/tumor?	☐	☒
b. Prostate enlargement, prostate cancer, testicular mass, or sexually transmitted diseases?	☐	☒
c. Other disorder of the reproductive organs or breasts?	☐	☒
12. Disorder of the muscles, joints, bones, tendons, ligaments, soft tissues, spine or back including arthritis, fracture, chronic pain, or herniated disc, chronic fatigue syndrome, or fibromyalgia?	☐	☒
13. Disease of eyes, ears, nose, or throat?	☐	☒
14a. Psychological or psychiatric disorders including depression, bipolar disorder, obsessive compulsive disorder, schizophrenia, attention deficit disorders, affective disorders, eating disorder, or any other mental or behavioral disorder or disease?	☐	☒
b. Alcoholism, drug dependency or addiction?	☐	☒
15. Any other mental or physical disease or disorder not listed above?	☐	☒

DETAILS of yes answers. Identify question number. Circle applicable items. Include diagnosis and name and address of medical provider(s) consulted. (Use page 2 if additional space is needed.)

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company

MEDICAL EXAMINATION

(Part 2 (continued) of an application to Nationwide Insurance for Life or Health Insurance)

Have you in the past 10 years:

		Yes	No	
16a.	Been a patient (including outpatient) in a hospital, clinic, mental health facility, or other medical facility?	☐	☑	
b.	Consulted or been referred to any physician not listed above?	☐	☑	
c.	Been advised to have surgery, hospitalization, testing, or treatment that was not completed?	☐	☑	
17a.	Used tobacco? *(If yes, specify dates and form of tobacco used.)*	☐	☑	
b.	Used alcoholic beverages? *(If yes, how much, what kind (beer, wine, liquor), how often?)*	☑	☐	occasional - social
c.	Used any illegal, restricted, or controlled substance except as prescribed by a physician? *(If yes, provide details.)*	☐	☑	
18.	Requested or received a pension, benefits, or payment because of injury, sickness or disability?	☐	☑	

ADDITIONAL SPACE FOR DETAILS OF YES ANSWERS. *(Identify question number.)*

19.	Living	Health Concerns or Cause of Death	Age or Age at Death	Brother or Sister?	Living	Health Concerns or Cause of Death	Age or Age at Death
Father	Y (N)	leukemia	79		(Y) N		
Mother	(Y) N				(Y) N		
					Y N		
					Y N		

Other family members with diabetes, heart disease, cancer, kidney disease or other inheritable conditions?

All the statements and answers on this form are complete and true to the best of my knowledge and belief, whether written by my own hand or not; and I agree that they are to be the basis for any insurance issued hereon. I authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any other organization, institution, or person who has knowledge of me (or of any other person who is proposed for insurance); to give that information to the Medical Director of the Nationwide Life Insurance Company, or its reinsurers. This authorization, or a copy of it, will be valid for a period of not more than thirty (30) months from the date it was signed.

Signed this day of 11 Month/Day 2003 Year

Signed _____ Signature of Medical Examiner _____ Signature of Proposed Insured

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20. AGREEMENT, AUTHORIZATION AND SIGNATURES

I have read this application. I understand each of the questions. All of the answers and statements on this form are complete and true to the best of my knowledge and belief. I understand and agree that:

A. This application, any amendments to it, and any related medical examinations will become a part of the Policy and are the basis of any insurance issued upon this application.

B. No medical examiner, producer or other representative of Nationwide may accept risks or make or change any contract, or waive or change any of the Company's rights or requirements.

C. If the full first premium payment is made in exchange for a Temporary Insurance Receipt, Nationwide will only be liable to the extent set forth in that receipt.

D. If the full first premium is not paid with this application, then insurance will only take effect when all of the following conditions are met:
1. a Policy is issued by Nationwide and is accepted by me; and
2. the full first premium is paid, and
3. all the answers and statements made on the application, medical examination(s) and amendments continue to be true to the best of my knowledge and belief.

The applicant has a right to cancel this application at any time by contacting their agent or Nationwide in writing. I have received the pre-notice form of the Fair Credit Reporting act of 1970 and the Medical Information Bureau disclosure form. I certify that the Social Security Number given is correct and complete.

I authorize any licensed physician or medical practitioner, any hospital, clinic, pharmacy or other medical or medically related facility; any insurance company, the Medical Information Bureau, or any other organization, institution or person who has knowledge of me, to give that information to the Medical Director of the Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, or its reinsurers, for the purpose of underwriting my application in order to determine eligibility for Life insurance and to investigate claims. By my signature below, I acknowledge that any agreements I have made to restrict any protected health information do not apply to this authorization; and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This authorization, or a copy of it, will be valid for a period of not more than two and one-half years (30 months) from the date it was signed. I understand that I have the right to revoke this authorization in writing, at anytime, by sending a written request for revocation to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, Attention: Underwriting, PO Box 182835, Columbus, Ohio 43218-2835. I understand that a revocation is not effective to the extent that any of my providers have relied on this authorization, or to the extent that Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I further understand that if I refuse to sign this authorization to release my complete medical records, Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company may not be able to process my application. I understand that my authorized representative or I have a right to a copy of this authorization by sending a request to Nationwide in writing.

Signed at Birmingham, Michigan (City/State) on November 15 (Month/Day) 2003 (Year)

I have truly and accurately recorded all Proposed Insured's answers on this application and have witnessed his/her/their signature(s) hereon.

To the best of my knowledge, the insurance applied for ☐ will ☒ will not (CHECK ONE) replace any life insurance, and/or annuity.

Gary Herman Lovisoff
Name of Proposed Insured (please print)

Signature of Proposed Insured (or parent if Proposed Insured is under age 15)

Name of Joint/Spouse Proposed Insured (please print)

Signature of Joint/Spouse Proposed Insured (if to be insured)

Signature of Applicant/Owner (if other than the Insured)

Signature of Payor (if other than the Insured)

Matt E. Rauch
Producer's Name (please print)

Producer's Signature

Rauch Agency 21-0024503
Firm / Producer's Nationwide Number

[redacted]
Social Security Number

L-4738-21 Page 7

DUPLICATE

GUARANTEED TERM LIFE INSURANCE TO AGE 95 POLICY

Renewable once a year until age 95.
Convertible anytime prior to the end of the conversion period, as stated on the policy data pages.
Premiums payable during lifetime of Insured prior to the end of the term of the policy.
Premiums are guaranteed at issue.
Non-Participating - No Dividends.

EXHIBIT

B

APPLICATION FOR CHANGE OF BENEFICIARY DESIGNATION

Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company

Policy Number: L0349043OO Primary Insured: Gary H. Lajoie Insured's SSN: [redacted]

Please see Page 3 of this application for important information. Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company, are herein referred to as "the Company".

This designation is for: ☒ Primary/Base Insured ☐ Joint/Spouse Rider ☐ Other: _____ (Name of Insured or Rider)

Note: If none selected, this change will be in effect for Primary/Base Insured only.

Primary Beneficiary Designation

A. ☒ The following person(s) who survive the Insured, in equal shares or noted percentages:

Full Name	Relationship to Insured	Full Address	SSN	%
William Keene	Business Relationship	[redacted]	[redacted]	100%

Total = 100%

B. ☐ The Executors or Administrators of the Estate of the Insured.

C. ☐ Trust (Please include a copy of the pages from your trust that contain the following information: the title of the trust, date established, trustees' names, and signatures).

Named Trustee(s) _____

Title/Name of Trust _____ or successor(s).

Date of Trust: _____

D. ☐ Trustee(s), or successor(s) in trust under Insured's Last Will and Testament

E. ☐ Other (please specify): Name: _____

Address: _____

Contingent Beneficiary Designation

If Primary Beneficiary is deceased at the time of Insured's death, or is not in existence (if trust, corporation or other entity) at time of Insured's death, then to:

A. ☒ The following person(s) who survive the Insured, in equal shares or noted percentages:

Full Name	Relationship to Insured	Full Address	SSN	%
Jennifer Keene	Wife of William Keene	[redacted]		100%

Total = 100%

B. ☐ The Executors or Administrators of the Estate of the Insured.

C. ☐ Trust (Please include a copy of the pages from your trust that contain the following information: the title of the trust, date established, trustees' names, and signatures).

Named Trustee(s) _____

Title/Name of Trust _____ or successor(s).

Date of Trust: _____

D. ☐ Trustee(s), or successor(s) in trust under Insured's Last Will and Testament

E. ☐ Other (please specify): Name: _____

Address: _____

Nationwide

APPLICATION FOR CHANGE OF BENEFICIARY DESIGNATION
Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company

Policy Number: L034804300 Primary Insured: Gary H. Lupiloff Insured's SSN: [redacted]

I hereby acknowledge that I have read and agree to the terms and conditions on page 3 of this application. I agree that this change of beneficiary is effective the date of this application and this application will have no effect on any payment made or action taken by the Company before the Company has agreed to this application.

Owner signed and witnessed in (city/state)	Bremerton, MI
Owner's Signature	X [signature]
Owner's Printed Name	GARY H. LUPILOFF
Date Signed	4/4/07
Owner's Witness Printed Name	MARY B. RAUH
Owner's Witness Signature	[signature]
Date Signed	4/4/07
Joint Owner/Other signed and witnessed in (city/state)	
Joint Owner's/Other's Signature (if applicable)	
Joint Owner's/Other's Printed Name	
Date Signed	
Joint Owner's/Other's Witness Signature	
Joint Owner's/Other's Witness Printed Name	
Date Signed	

Agreed to for Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company by Thomas Barnes, Secretary

[signature]

APPLICATION FOR CHANGE OF BENEFICIARY DESIGNATION

Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company
Mail to: Nationwide Life Insurance Company, P O. Box 182835, Columbus, Ohio 43218-2835
Contact us at 1-800-543-3747, or visit our website at www.nationwidefinancial.com
Fax: 1-614-677-6189

About Designations

- **Completing this form:** It is important that you fully complete Section 1 of this form, even if you are not making any changes to the primary beneficiary (i.e. fully writing out the designation including names and percentages if applicable). We will not accept wording such as "same" or "no change" in Section 1 or Section 2 of forms where Section 1 is left blank.
- **Dollar Amounts:** Specific dollar amounts are generally not permitted. Instead, please designate a percent in the % column. Percentage totals must equal 100 percent. If you must designate a specific dollar amount, please contact our Home Office.
- **Funeral Home or Creditor:** If you wish to name a funeral home or creditor, please use the "Other" field for this designation. Please use the following wording and complete the items listed in parenthesis: "(Creditor Name or Funeral Home Name), as their interest may appear, balance if any to (whomever you wish to designate)"
- **Businesses, Schools, Charities, or Churches:** If you wish to name a business, school, charity, or church as your beneficiary, please use the "Other" field for this designation.
- **Irrevocable beneficiary:** An irrevocable beneficiary, once named, cannot be changed without the consent of the named irrevocable beneficiary. In addition, other policy changes may require the irrevocable beneficiary's signature prior to the Company accepting any requested change. If this beneficiary is to be irrevocable, please add the following wording after the person's name: "without right of revocation during this beneficiary's lifetime or existence and no longer".

Terms and Conditions

- **Sending your policy:** Please do not send in your policy with this request. The Company waives any policy provision requiring the return of the Policy to the Company for endorsement.
- **Previous beneficiary designations:** Once the Company receives and agrees to this application, all previous beneficiary designations for this policy are revoked effective the date of this application. If a death claims becomes payable under this policy, the proceeds shall be payable to the beneficiary(ies) named in this application after the Application has been accepted by the Company.
- **Unless otherwise provided for on this application:**
  - If two or more Beneficiaries or Contingent Beneficiaries are designated, the proceeds shall be payable in equal shares to those Beneficiaries or Contingent Beneficiaries who survive the insured.
  - If two or more Beneficiaries or Contingent Beneficiaries are designated to receive the proceeds in unequal shares and any of those Beneficiaries or Contingent Beneficiaries predecease the Insured, the proceeds designated for such deceased Beneficiaries or Contingent Beneficiaries shall instead be paid in equal shares to those Beneficiaries or Contingent Beneficiaries who survive the Insured.
  - Children include naturally born and legally adopted children of the Insured.
  - Any amounts payable to a child of less than legal age shall be paid to the legally appointed guardian of his/her property or in any other manner approved by the laws of the state where payment is made.
- **Beneficiaries not specified by name:** If beneficiary(ies) are not specified by name (i.e. all children living), the Company is authorized to rely on an affidavit from any beneficiary listed on this form or from any responsible person in determining the names of the beneficiaries at time of claim. The Company is discharged from all liability upon making settlement based on such affidavit.
- **Required Addresses:** If you live in one of the following states - AK, AZ, FL, HI, ID, LA, NO, OR, RI, UT, VA, WA or WI, a full address for all beneficiaries designated is required.
- **Required Signatures:** This request must be signed and dated by all persons who have ownership or other rights in the policy (all co-owners, joint owners, co-trustees, previously named irrevocable beneficiaries, etc.). Signatures must be made in ink using full legal names. In addition:
  - If a corporation owns the policy, we require the signature of a corporate officer and the officer's title. This officer must be someone other than the Insured unless the Insured is the sole corporate officer.
  - In states that require a witness, an uninterested party should sign as the witness (someone not named as a beneficiary or otherwise signing this form.).
- **Owners' rights:** The owner(s) reserve the right to change the beneficiary unless otherwise provided for on this application (i.e. irrevocable beneficiary(ies)).
- **If a Trust/Trustee(s) is named as beneficiary on this policy:**
  - The Company is not responsible for the application or disposition of the proceeds of the policy by the Trustee(s). Payment to the Trustee(s) shall fully discharge the liability of the Company under the policy.
  - If the beneficiary is a testamentary trust, the Company is authorized to rely on a certified copy of the qualification and appointment of the trustee or the probating of the will. If the beneficiary is an inter vivos or living trust, the Company is authorized to rely upon a statement from the trustees that the trust is active.
  - If, within six months after the death of the insured, the Company has not been furnished with evidence of the probating of the Will and the qualification of the trustee (if a testamentary trust), or, with evidence that the trust is active and in full force and effect (if an inter vivos or living trust), the proceeds may then be paid to the contingent or other beneficiary(ies) designated to next receive the proceeds. If there are no such beneficiaries, the proceeds may then be paid according to the terms of the policy when no beneficiary is living at the death of the Insured.
- **Executors, Administrators or Estates as beneficiaries:** For policies in which the Insured's Estate or the Executor or Administrator of the Insured's Estate is the beneficiary, the Company is authorized to rely upon a certified copy of the qualification and appointment of the Executor or Administrator of the Insured's Estate. Payment of the policy's proceeds to the Executor or Administrator shall fully discharge the liability of the Company under the policy.
- Any reference in this Application to a beneficiary living or surviving will mean living or surviving at the time of the Insured's death.

EXHIBIT

C

NATIONWIDE LIFE INSURANCE COMPANY
APPLICATION FOR DESIGNATION OF OWNER AND/OR CONTINGENT OWNER

Policy Number: L0348043**00** Insured: GARY H LUPLOFF

I, the present owner of the above numbered policy, hereby revoke any previous designation of Owner and/or Contingent Owner, and I hereby designate as the Owner and/or Contingent Owner of the said policy effective this date in accordance with the policy provisions, the following:

If more than one owner, ownership will be vested jointly or in the survivor(s), but if none are living or in existence, then in the contingent owner(s), if any, jointly or in the survivor(s), otherwise to the Executor or Administrator of the Estate of the last said owner.

NEW OWNER: Social Security or Taxpayer Identification Number: [redacted]

FULL NAME	DATE OF BIRTH	RELATIONSHIP TO INSURED
William Kerner	[redacted]66	Business Relationship on file

ADDRESS

NEW CONTINGENT OWNER: Social Security or Taxpayer Identification Number: ___ - ___ - ___

FULL NAME	DATE OF BIRTH	RELATIONSHIP TO INSURED

ADDRESS

Premium Notices Shall be sent to the new owner for the above mentioned policy, unless checked and completed below:

☐ Premium Payor to be _____ Address of Payor _____
Print full name of Payor Print full address of Payor

I understand that this change in ownership does not in any way affect the Beneficiary designations of the policy. In the event this application designates a change of Owner and if the Owner's Benefit(s) is included in said policy, I hereby surrender such Benefit(s) and acknowledge that such Benefit(s) is hereby terminated, and in consideration thereof the premium shall be reduced and unearned premium, if any, adjusted effective this date.

POLICY MODIFICATION: Any provision of the policy stipulating that the policy shall be returned to the Company for endorsement in order to effect a change of Ownership is hereby waived by the Company and the Owner, and it is agreed that such change shall take effect as of the date of this application, subject to any payment made or action taken by the Company before this application has been agreed to by the Company.

Under the Interest and Dividend Compliance Act of 1983, persons owning insurance policies are required to provide the Company with certification that their taxpayer identification number is correct. (For most individuals, this is their Social Security Number.) If they do not provide us with certification of this number, they may be subject to a $50 penalty imposed by the Internal Revenue Service. In addition, we will be forced to withhold 31% or such rate as required by law from interest and other payments we make to you. This is called backup withholding (and is not the same as the 10% withholding on interest and dividends that was repealed in 1983.) It is not an additional tax, since the tax liability of persons subject to backup withholding will be reduced by the amount of the tax withheld. If withholding results in an overpayment of taxes, a refund may be obtained. Check this box [ ] if the Internal Revenue Service has notified you that we are not subject to the provisions of this law. Otherwise, your signature on this application serves as certification under penalties of perjury, that the taxpayer identification number on this application is true, correct, and complete.

Signed at Birmingham MI this 4 day of April 2007
City, State

New Owner's Signature

Present Owner's Signature

HOME OFFICE USE ONLY

Agreed to for Nationwide Life Insurance Company

Life-1112-M

Complete and send to Company at Columbus, Ohio 43215
DO NOT SEND POLICY

(03/2002)

NATIONWIDE LIFE INSURANCE COMPANY
APPLICATION FOR DESIGNATION OF OWNER AND/OR CONTINGENT OWNER

The following instructions have been enclosed to assist you with the completion of the attached APPLICATION FOR DESIGNATION OF OWNER AND/OR CONTINGENT OWNER. Please read these instructions carefully before completing the application.

1. Use this form to request a change of policy ownership. If the desired change of ownership is complex, or if you have any questions, please contact Nationwide Life Insurance Company at the Home Office.

2. This application revokes ALL previous ownership. Therefore, even if the present owner or contingent owner is to remain the same, such owner must be renamed on this form.

3. Print the FULL name(s) and address(es) of the new owner(s). Be certain to provide the new date of birth, social security (or tax ID) number, relationship to the insured and the complete address. THE REQUESTED CHANGE OF OWNERSHIP WILL NOT BE PROCESSED IF ANY OF THE INFORMATION IS OMITTED.

4. SIGNATURES REQUIRED: (1) The present owner(s) and all irrevocable beneficiaries, if any, and (2) the proposed new owner(s). Signatures MUST be in ink. At the discretion of the Home Office, a witness may be required.

5. The new owner will receive the premium notices unless the payor information is completed.

6. If joint ownership is listed, all notices will be mailed to one address listed on the reverse side. For tax reporting purposes, only one social security number can be used. Please indicate which social security number is to be used. The signatures of all joint owners will be required for any policy changes requiring an application. If any of the joint owners is a minor, the minor's legal representative will be required to authorize changes for him/her.

7. If naming a trust as owner, provide the name of the trustee(s), the name of the trust, and the date the trust was executed on this form. A copy of evidence of the existence of the trust must be provided. Please provide us with a copy of the page or pages of the trust showing the name and date of the trust, the names of trustor and trustee(s), and a copy of the signature page of the trust.

8. If naming a corporation as the new owner, we will need the full name and address of the corporation. We require the signatures of the present policy owner and an authorized officer (with current job title), other than the insured, to sign as the new owner on behalf of the corporation. For variable life insurance products, we require a certified copy of the corporate resolution providing such authority, to be submitted with the Application for Designation of Owner form. If a corporation is named as new owner and the insured is the sole officer, then we will require a completed "Sole Corporate Officer Certification." This form, which can be obtained from Nationwide Life Insurance Company at the Home Office, must be notarized and submitted with the Application for Designation of Owner form.

9. Complete and send to Nationwide Life Insurance Company, PO Box 182835, Columbus, Ohio 43218-2835.

EXHIBIT

D

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
Nationwide Life Insurance Company of America
Nationwide Life and Annuity Company of America
P.O. Box 182835, Columbus, OH 43218-2835
Hereinafter referred to as the Company
www.nationwide.com

BENEFICIARY CLAIM FORM

Customer Contact Information
Nationwide: 1-800-243-6295
TDD: 1-800-238-3035
Fax: 1-888-677-7393

Section 1: General Information – Please print.

Please accept our deepest sympathies for your loss. This form is designed to collect information needed to complete your claim.

IMPORTANT: ***Sections 1, 2, and 5 must be completed.***

A certified Death Certificate bearing the seal of the appropriate local, state or federal agency issuing the certificate must accompany this completed form.

Each beneficiary must complete a separate claim form.

To expedite the processing of this claim, you can fax the completed claim form along with a copy of the certified death certificate to 1-888-677-7393.

1a. Deceased Information.

Existing Policy Number(s) (required): L034804300
Deceased First Name: GARY
Deceased Last Name: LUPILOFF
Date of Death: JULY 13, 2010

1b. Beneficiary Information. Must be completed.

Beneficiary Name: Nicole Renee Lupiloff
Residential Address (PO Box address is not accepted): C/O Albert Holtz 3910 Telegraph Ste 200
City/State/Zip Code: Bloomfield Hills MI 48302
Mailing Address (if different than residential): SAME AS ABOVE
City/State/Zip Code:
SSN: [redacted] Date of Birth: [redacted]
Daytime Telephone Number: [redacted] E-Mail: [redacted]

The next Section, **Settlement Options**, provides three distribution options for your death benefit proceeds. For information about what other options are available to you, please call us at 1-800-243-6295 or TDD: 1-800-238-3035.

Section 2: Settlement Options – Please select one option.

Please Note: Policy owners have the option to choose in advance how their beneficiaries will receive the money. If that is the case for you, we'll carry out the policy owner's instructions and provide complete details to you in writing.

☐ **Option 1 – Lump Sum Payment Option – Nationwide Bank Secure Money Market Account**

We will establish a Nationwide Bank Secure Money Market Account in the beneficiary's name and deposit all proceeds into the account. You will have immediate access to these proceeds by check and this account will earn interest.

Benefits of the Nationwide Bank Secure Money Market Account:

- An attractive variable tiered rate of interest.
- A safe account to hold funds separate from your everyday funds.
- FDIC insurance coverage, up to $250,000 per depositor.
- Free personalized checks provided by Nationwide Bank.
- Dedicated Customer Care Specialists ready to help you when you call them at 1-877-422-6569.
- No monthly service fees.

The following fields **MUST** be completed for the Nationwide Bank Secure Money Market Account option:

ID#: _____ Issue State: _____ ☐ Driver's License ☐ Military ID ☐ State ID

Please note: For your protection, accounts are reviewed under US banking rules to confirm eligibility. Interest earned is reportable to the IRS. Please consult your tax advisor for additional information.

☒ **Option 2 – Lump Sum Payment Option – Single Check or Direct Deposit**

This option provides a single full payment. You can choose from receiving the death benefit proceeds either in the form of a check or have it transferred to your checking or savings account.

Benefits of a Single Check:

- One transaction access to your money.
- Flexibility to transfer directly into your checking or savings account.

Important: Please select either check or direct deposit from below.

☒ Check (a check will be mailed to you using the address entered on page 1, section 1b.).
☐ Direct Deposit (complete the information and follow the instructions below).

Financial Institution Name: _____

Financial Institution Phone Number: (___) _____

You must attach a voided check if depositing into your checking account. If depositing into your savings account, a letter from your financial institution will be required. The deposit into your checking or savings account will normally occur four (4) business days after the date the claim transaction is processed. Please note deposit slips are not acceptable.

Important: If a voided check (or letter from your bank/financial institution) is not included, a check will automatically be mailed to the address you provided us. The checking/savings accountholder must be the same as the beneficiary.

Section 3: Taxpayer ID Certification

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Certification – Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct taxpayer identification number, and

(2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and

(3) I am a United States citizen (including a U.S. resident alien).

You must cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.

Section 4: State Fraud Statements

Alabama, Alaska, Arizona, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, Mississippi, Ohio, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Dakota, Texas, Utah, Vermont, West Virginia, Wisconsin and Wyoming Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

Arkansas Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Important Notice: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department or regulatory agencies.

District of Columbia. Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas, Nevada, North Carolina and North Dakota Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

Louisiana Caution: If your answers on this application are incorrect or untrue, Nationwide has the right to deny benefits or rescind your policy. Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Missouri Caution: If your answers on this application are incorrect or untrue, Nationwide has the right to deny benefits or rescind your policy. Fraud Statement: Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

Section 4: State Fraud Statement, continued

New Jersey Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Virginia Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Washington Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

Section 5: Authorization – Signature Required

If I selected the Nationwide Bank Secure Money Market Account Option, I understand and agree, by signing this form that Nationwide Bank will access and utilize consumer report information to open my account. I authorize my information to be shared with Nationwide Bank, for purposes of establishing my Secure Money Market Account. To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for me: When I open an account, Nationwide Bank asks for my name, address, date of birth, and other information that will allow them to identify me. Nationwide Bank may ask to see my driver's license or other identifying documents.

I certify under penalties of perjury that all statements are true, correct and complete to the best of my knowledge and belief. I understand that the furnishing of this form by the Company does not constitute an admission that there is any insurance in force.

Signature of Beneficiary *(Individual Beneficiary)*	Date	Social Security Number
Nicole R Taylor	12/13/10	[redacted]
Signature of Legally Appointed Guardian	Date	Minor Beneficiary's Social Security Number

(Individual Beneficiary is a minor or mentally incompetent person) A certified copy of guardianship papers must be furnished.

Please contact our Customer Service Center at 1-800-243-6285 if you have any questions. If you have a Telecommunications Device for the Deaf (TDD), you may access our TDD services at 1-800-238-3035. Customer Service Representatives are available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. EST.

To expedite the claim process, you may overnight the completed claim form along with any other required form(s) to the following address:

Nationwide Life Operations
RR1 - 04 - D4
5100 Rings Rd.
Dublin, Ohio 43017

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF DEATH

1016

STATE FILE NUMBER 3328231

1. DECEDENT'S NAME: Gary Harmon Lupiloff
2. DATE OF BIRTH: [redacted]
3. SEX: Male
4. DATE OF DEATH: [redacted]
5a. LOCATION OF DEATH: William Beaumont Hospital
5b. CITY, VILLAGE, OR TOWNSHIP OF DEATH: Royal Oak
5c. COUNTY OF DEATH: Oakland
6a. DECEDENT RESIDENCE - STATE: Michigan
6b. COUNTY: Oakland
6c. CITY/TOWN: Royal Oak
6d. STREET AND NUMBER: [redacted]
6e. ZIP CODE: 48073
9. BIRTHPLACE: Detroit, Michigan
10. SOCIAL SECURITY NUMBER: [redacted]
11. DECEDENT'S EDUCATION: Law Degree
12. RACE: White
13a. ANCESTRY: Russian
13b. HISPANIC ORIGIN: No
14. WAS DECEDENT EVER IN THE U.S. ARMED FORCES: No
15. USUAL OCCUPATION: Executive
16. KIND OF BUSINESS/INDUSTRY: Advertising
17. MARITAL STATUS: Divorced
18. SURVIVING SPOUSE: (If wife, give maiden name)
19. FATHER'S NAME: Albert Lupiloff
20. MOTHER'S NAME BEFORE FIRST MARRIED: Marion Goldman
21a. INFORMANT'S NAME: Marian Lupiloff
21b. RELATIONSHIP TO DECEDENT: Mother
21c. MAILING ADDRESS: [redacted]
22. METHOD OF DISPOSITION: Burial
23a. PLACE OF DISPOSITION: Clover Hill Park Cemetery
23b. LOCATION - City or Village, State: Birmingham, Michigan
24. SIGNATURE OF MORTUARY/CREMATORY OFFICIAL: [signature]
25. LICENSE NUMBER: 5444
26. NAME AND ADDRESS OF FUNERAL FACILITY: Ira Kaufman Chapel, Inc. 18325 W 9 Mile, Southfield, Michigan 48075
27a. CERTIFIER: [signature] Coroner
27b. ACTUAL OR PRESUMED TIME OF DEATH: Unknown
28a. PRONOUNCED DEAD ON: July 13, 2010
28b. TIME PRONOUNCED DEAD: 5:48 PM
29. WAS MEDICAL EXAMINER CONTACTED: Yes
30. PLACE OF DEATH: Hospital
31. IF HOSPITAL, DOA
27c. DATE SIGNED: July 14, 2010
27d. LICENSE NUMBER: 57360
32. MEDICAL EXAMINER'S CASE #: 10-2668
33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER: Kanu Virani, M.D.
34. NAME AND ADDRESS OF CERTIFIER: Kanu Virani, M.D., 1200 North Telegraph Road, Pontiac, MI 48341-0438
35a. REGISTRAR'S SIGNATURE: Melanie Halas
35b. DATE FILED: JUL 19 2010

CAUSE OF DEATH
36. PART I. Enter the chain of events, diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT abbreviate. Enter only one cause on a line. Add additional lines if necessary.
a. Gunshot Wound of Back — Minutes
b.
c.
d.
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.
38. DID TOBACCO USE CONTRIBUTE TO DEATH? No / Unknown
39. IF FEMALE: Not pregnant within past year / Not pregnant, but pregnant 42 days to 1 year before death / Unknown if pregnant within the past year
40. MANNER OF DEATH: HOMICIDE
40a. WAS AN AUTOPSY PERFORMED? Yes
40b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Yes
41a. DATE OF INJURY: July 13, 2010
41b. TIME OF INJURY: Approx. 3:00 PM
41c. DESCRIBE HOW INJURY OCCURRED: Shot by other person
41d. INJURY AT WORK? No
41e. PLACE OF INJURY - At home, farm, street, factory, office building, restaurant, etc.: Driveway
41f. IF TRANSPORTATION INJURY - State: [redacted]
41g. LOCATION - Street or R.F.D. No., City, Village or Twp., State: [redacted]

MEDICAL EXAMINER

DOCUMENT PREPARER

I, Melanie Halas, Clerk of the City of Royal Oak, Oakland County, Michigan, do hereby certify that the foregoing is a true copy of the record now remaining in my office

304381

Melanie Halas
City of Royal Oak, Michigan

This copy is not valid unless displaying embossed seal and registrar signature.

WARNING: It is illegal to duplicate this copy by Photostat or Photograph. VALID ONLY WITH EMBOSSED SEAL

Gary Lupiloff

7 12/14/2010 3:18:52 PM [Central Standard Time] OHCOLAPP0736 7393 248 593 5040 02-18 NFVISA

EXHIBIT

E

Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
Nationwide Life Insurance Company of America
Nationwide Life and Annuity Company of America
P.O. Box 182029, Columbus, OH 43218-2029
Home office referred to as the Company
www.NFSmobile.com

BENEFICIARY CLAIM FORM

Customer Contact Information
Nationwide: 1-800-243-0295
TDD: 1-800-238-3035
Fax: 1-888-677-7203

Section 1: General Information – Please print.

Please accept our deepest sympathies for your loss. This form is designed to collect information needed to complete your claim.

IMPORTANT: *Sections 1, 2, and 5 must be completed.*

A certified Death Certificate bearing the seal of the appropriate local, state or federal agency issuing the certificate must accompany this completed form.

Each beneficiary must complete a separate claim form.

To expedite the processing of this claim, you can fax the completed claim form along with a copy of the certified death certificate to 1-888-677-7203.

1a. Deceased Information.

Existing Policy Number(s): L034804300 (required)

Deceased First Name: GARY

Deceased Last Name: LUPILOFF

Date of Death: JULY 13, 2010

1b. Beneficiary Information. Must be completed.

Beneficiary Name: MONICA LYNN LUPILOFF

Residential Address: C/O Albert Hoitz 3910 Telegraph Ste 200
(PO Box address is not accepted)

City/State/Zip Code: Bloomfield Hills MI 48302

Mailing Address: SAME AS ABOVE
(If different than residential)

City/State/Zip Code:

SSN: [redacted] Date of Birth: [redacted]

Daytime Telephone Number: [redacted] E-Mail: [redacted]

The next Section, Settlement Options, provides three distribution options for your death benefit proceeds. For information about what other options are available to you, please call us at 1-800-243-0295 or TDD: 1-800-238-3035.

Section 3: Taxpayer ID Certification

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Certification -- Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct taxpayer identification number, and

(2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and

(3) I am a United States citizen (including a U.S. resident alien).

You must cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.

Section 4: State Fraud Statements

Alabama, Alaska, Arizona, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, Mississippi, Ohio, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Dakota, Texas, Utah, Vermont, West Virginia, Wisconsin and Wyoming Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

Arkansas Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Important Notice: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia. Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas, Nevada, North Carolina and North Dakota Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

Louisiana Caution: If your answers on this application are incorrect or untrue, Nationwide has the right to deny benefits or rescind your policy. Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Missouri Caution: If your answers on this application are incorrect or untrue, Nationwide has the right to deny benefits or rescind your policy. Fraud Statement: Any person who submits an application or a claim containing a false or deceptive statement, and does so with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, may be guilty of insurance fraud.

Section 4: State Fraud Statement, continued

New Jersey Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Virginia Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Washington Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

Section 5: Authorization & Signature Required

If I selected the Nationwide Bank Secure Money Market Account Option, I understand and agree, by signing this form that Nationwide Bank will access and utilize consumer report information to open my account. I authorize my information to be shared with Nationwide Bank, for purposes of establishing my Secure Money Market Account. To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for me: When I open an account, Nationwide Bank asks for my name, address, date of birth, and other information that will allow them to identify me. Nationwide Bank may ask to see my driver's license or other identifying documents.

I certify under penalties of perjury that all statements are true, correct and complete to the best of my knowledge and belief. I understand that the furnishing of this form by the Company does not constitute an admission that there is any insurance in force.

M Dugaloff — 12/14/10 — [redacted]

Signature of Beneficiary (Individual Beneficiary) — Date — Social Security Number

Signature of Legally Appointed Guardian — Date — Minor Beneficiary's Social Security Number

(Individual Beneficiary is a minor or mentally incompetent person) A certified copy of guardianship papers must be furnished.

Please contact our Customer Service Center at 1-800-243-8295 if you have any questions. If you have a Telecommunications Device for the Deaf (TDD), you may access our TDD services at 1-800-238-3035. Customer Service Representatives are available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. EST.

To expedite the claim process, you may overnight the completed claim form along with any other required form(s) to the following address:

Nationwide Life Operations
RR1 - 04 - D4
5100 Rings Rd.
Dublin, Ohio 43017

EXHIBIT

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Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company
Nationwide Life Insurance Company of America
Nationwide Life and Annuity Company of America
P.O. Box 182835, Columbus, OH 43218-2835
Hereinafter referred to as the Company
www.nationwide.com

BENEFICIARY CLAIM FORM

Customer Contact Information
Nationwide: 1-800-243-6295
TDD: 1-800-238-3035
Fax: 1-888-677-7393

Section 1: General Information – Please print.

Please accept our deepest sympathies for your loss. This form is designed to collect information needed to complete your claim.

IMPORTANT: ***Sections 1, 2, and 5 must be completed.***

A certified Death Certificate bearing the seal of the appropriate local, state or federal agency issuing the certificate must accompany this completed form.

Each beneficiary must complete a separate claim form.

To expedite the processing of this claim, you can fax the completed claim form along with a copy of the certified death certificate to 1-888-677-7393.

1a. Deceased Information.

Existing Policy Number(s): (required) L-0348043 00

Deceased First Name: GARY

Deceased Last Name: LUPILOFF

Date of Death: 7-13-2010

1b. Beneficiary Information. Must be completed.

Beneficiary Name: WILLIAM ISEENE

Residential Address: [redacted]
(PO Box address is not accepted)

City/State/Zip Code: [redacted]

Mailing Address:
(If different than residential)

City/State/Zip Code:

SSN: [redacted] Date of Birth: [redacted]

Daytime Telephone Number: [redacted] E-Mail: [redacted]

The next Section, **Settlement Options**, provides three distribution options for your death benefit proceeds. For information about what other options are available to you, please call us at 1-800-243-6295 or TDD: 1-800-238-3035.

Section 2: Settlement Options – Please select one option.

Please Note: Policy owners have the option to choose in advance how their beneficiaries will receive the money. If that is the case for you, we'll carry out the policy owner's instructions and provide complete details to you in writing.

☐ **Option 1 – Lump Sum Payment Option – Nationwide Bank Secure Money Market Account**

We will establish a Nationwide Bank Secure Money Market Account in the beneficiary's name and deposit all proceeds into the account. You will have immediate access to these proceeds by check and this account will earn interest.

Benefits of the Nationwide Bank Secure Money Market Account:

- An attractive variable tiered rate of interest.
- A safe account to hold funds separate from your everyday funds.
- FDIC insurance coverage, up to $250,000 per depositor.
- Free personalized checks provided by Nationwide Bank.
- Dedicated Customer Care Specialists ready to help you when you call them at 1-877-422-6569.
- No monthly service fees.

The following fields **MUST** be completed for the Nationwide Bank Secure Money Market Account option:

ID#: _____ Issue State: _____ ☐ Driver's License ☐ Military ID ☐ State ID

Please note: For your protection, accounts are reviewed under US banking rules to confirm eligibility. Interest earned is reportable to the IRS. Please consult your tax advisor for additional information.

☒ **Option 2 – Lump Sum Payment Option – Single Check or Direct Deposit**

This option provides a single full payment. You can choose from receiving the death benefit proceeds either in the form of a check or have it transferred to your checking or savings account.

Benefits of a Single Check:

- One transaction access to your money.
- Flexibility to transfer directly into your checking or savings account.

Important: Please select either check or direct deposit from below.

☒ Check (a check will be mailed to you using the address entered on page 1, section 1b.).
☐ Direct Deposit (complete the information and follow the instructions below).

Financial Institution Name: _____

Financial Institution Phone Number: (___) _____

You must attach a voided check if depositing into your checking account. If depositing into your savings account, a letter from your financial institution will be required. The deposit into your checking or savings account will normally occur four (4) business days after the date the claim transaction is processed. Please note deposit slips are not acceptable.

Important: If a voided check (or letter from your bank/financial institution) is not included, a check will automatically be mailed to the address you provided us. The checking/savings accountholder must be the same as the beneficiary.

Section 3: Taxpayer ID Certification

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Certification – Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct taxpayer identification number, and

(2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service has notified me that I am no longer subject to backup withholding, or that I am exempt from backup withholding, and

(3) I am a United States citizen (including a U.S. resident alien).

You must cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because of failure to report interest or dividends on your tax return.

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Section 5: Authorization -- Signature Required

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I certify under penalties of perjury that all statements are true, correct and complete to the best of my knowledge and belief. I understand that the furnishing of this form by the Company does not constitute an admission that there is any insurance in force.

Signature of Beneficiary *(Individual Beneficiary)*	Date	Social Security Number
	7-15-10	[redacted]
Signature of Legally Appointed Guardian	Date	Minor Beneficiary's Social Security Number

(Individual Beneficiary is a minor or mentally incompetent person) A certified copy of guardianship papers must be furnished.

Please contact our Customer Service Center at 1-800-243-6295 if you have any questions. If you have a Telecommunications Device for the Deaf (TDD), you may access our TDD services at 1-800-238-3035. Customer Service Representatives are available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. EST.

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Nationwide Life Operations
RR1 - 04 - D4
5100 Rings Rd.
Dublin, Ohio 43017